Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS RADIOLOGOY GROUP
PO BOX 29407
SAN ANTONIO TX 78229

Respondent Name
FACILITY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-0608-01

MFDR Date Received
NOVEMBER 2, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We were given Medicare & Humana at time services were rendered. It was not until 05/22/2012 that we received patients workers compensation information. Per TDI-DWC Rule §133.20 we had 95 days from the time we were notified of Workers Compensation Insurance to file this claim."

Amount in Dispute: $744.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier relies upon its review and reduction of the provider's bill as reflected in its EOBs. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2011	CPT Codes 72156-26, 72157-26, 72158-26, 74176-26	$725.90	$0.00
January 18, 2011	CPT Code 72100-26	$18.67	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
5. 28 Texas Administrative Code §180.22 sets out the guidelines for health care provided roles and responsibilities.
6. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 165 – Referral absent or exceeded.
   - 197 – recertification/authorization/notification absent
   - 29 – The time limit for filing has expired.
   - 859-000 – Payment denied/reduced for absence of or exceeded referral. No approved treatment.
   - 900-025 – The state specified time limit for submitting a medical bill has expired, therefore the service is not reimbursed.
   - 900-035 – Payment denied/reduced for absence of precertification/authorization.
   - 901 – Reconsideration no additional payment. Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the treating doctor of record refer the disputed services?
3. Was preauthorization required for the services in dispute
4. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied..." Review of the documentation submitted by the requestor finds that the requestor has submitted a copy of the electronic data transferred to Medicare; EOBs from Medicare and Humana with payments; and a refund request letter received from Humana on May 22, 2012. The requestor submitted Explanation of Benefits from the respondent with an audit date of July 6, 2012; therefore, convincing documentation was found to support the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute.
2. In accordance with 28 Texas Administrative Code 180.22 (c)The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall: (1) except in the case of an emergency, approve or recommend all health care reasonably required that is to be rendered to the injured employee including, but not limited to, treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers, as defined in this section. Review of the submitted documentation finds that the referring provider is Holger Skerhut; however, the treating doctor of record is Dr. James Walter Simmons, Jr. No documentation was submitted to support that the injured employee was referred to Holger Skerhut.
3. The services were also denied as 197 - "Precertification/authorization/notification absent." In accordance with 28 Texas Administrative Code 134.600(p) Non-emergency health care requiring preauthorization includes: (8)unless otherwise specified in this subsection, a repeat individual diagnostic study: (A)with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline, or (B)without a reimbursement rate established in the current Medical Fee Guideline. Review of the respondent's documentation finds that the carrier has not supported that the services rendered were repeat diagnostic studies. Therefore, the respondent's denials are not supported.
4. The Division has determined that the requestor has not supported the treating doctor of record referred the injured employee to Holger Kerhut; nor have they supported the treating doctor referred the diagnostic testing. Therefore reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 10,2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.